

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print) Corrie Garrie		Middle Scott		Last Baxter		2a. DATE OF DEATH Month March Day 31 Year 1968			2b. HOUR 5:30 P M		
3. SEX W/F		4. RACE American		5. DATE OF BIRTH 6-6-83		6. AGE (In years last birthday) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN. 	
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Kent			Md.		
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kent & Queen Anne Hosp.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Kent		13c. CITY OR TOWN Chestertown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 105 Water Street			
14. FATHER'S NAME First James Middle Scott Last Clothier				15. MOTHER'S MAIDEN NAME First Irea Middle Milvilla Last Stephenson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) no		16b. SOCIAL SECURITY NO. ?		17. INFORMANT Mrs. John Truslow Address Chestertown, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4129 Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease several years DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4321											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. 19 Month 3 Day 31 Year 1968 P.M. 		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State 							
22a. I certify that (I) (this hospital) attended the deceased from 3-19 , 19 68 , to 3-31 , 19 68 , that (I) (we) last saw the deceased alive on 3-31-68 , 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Dr. Robert W. Farr				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/1/68					
22d. PHYSICIAN'S NAME (Type) Dr. Robert W. Farr				22e. ADDRESS 305 Washington Ave. Chestertown, Md.							
23a. BURIAL-CREMATATION, REMOVAL (Specify) Apr 3, 1968		23b. DATE Apr 3, 1968		23c. NAME OF CEMETERY OR CREMATORY Church Hill		23d. LOCATION (City or Town) (County) (State) Church Hill Queen Anne's Md					
24. FUNERAL DIRECTOR Edgar L Lane				ADDRESS Church Hill Md		25a. REC'D BY REGISTRAR APR 5 - 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

MEDICAL CERTIFICATION

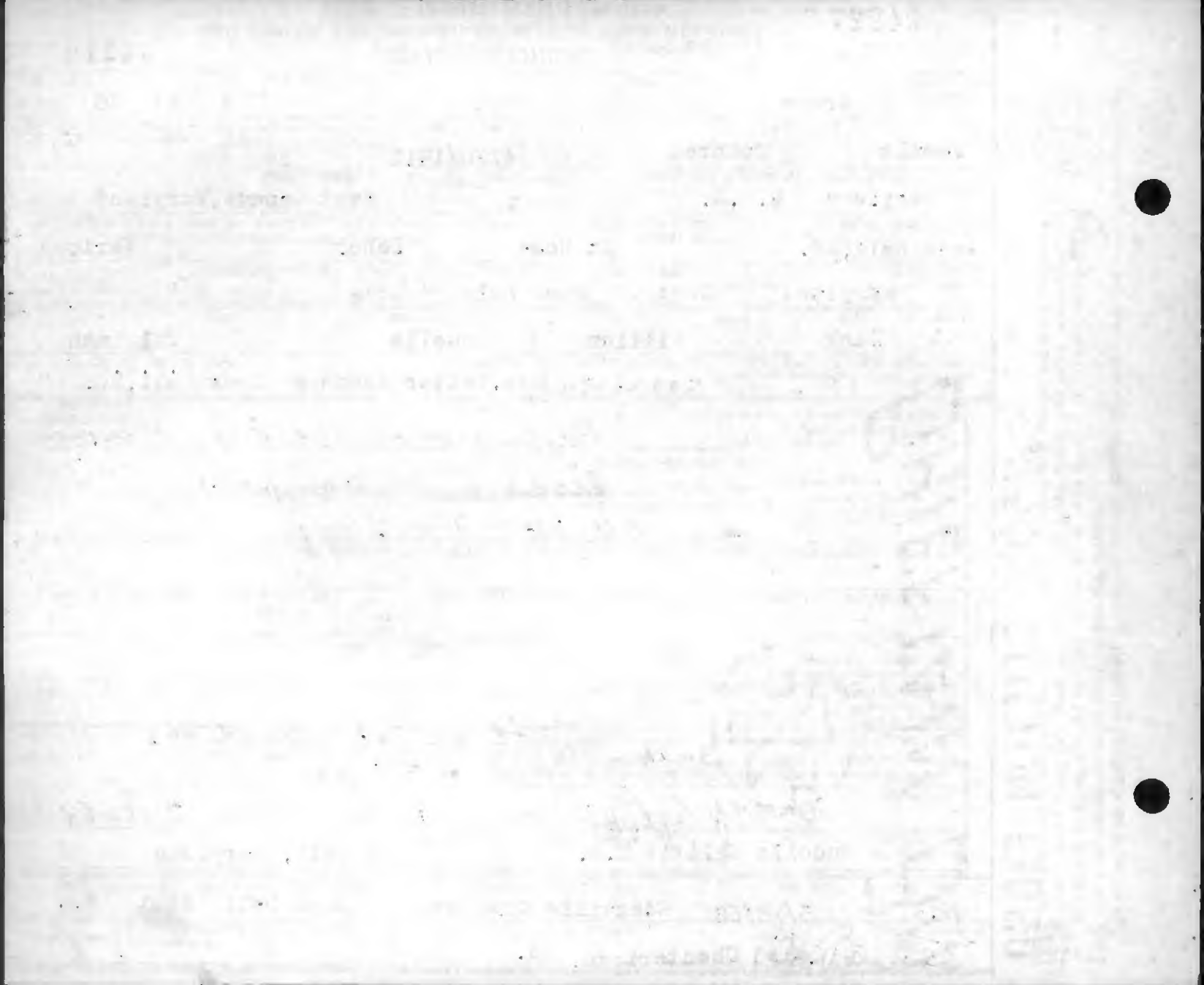
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04227										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										04212									
Item 8 Film G399 3/27/68 kk										CERTIFICATE OF DEATH																			
1. DECEASED-NAME (Type or print) Grace					First Middle Last Beck					2a. DATE OF DEATH Month 3 Day 14 Year 68					2b. HOUR M 														
3. SEX Female					4. RACE Colored					5. DATE OF BIRTH 4/28/1911					6. AGE (In years last birthday) 56 YRS.					IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.									
7a. BIRTHPLACE (State or foreign country) Maryland					7b. CITIZEN OF WHAT COUNTRY? U.S.A.					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH Kent County, Maryland Md.														
10. CITY OR TOWN OF DEATH Rock Hall, Md.					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) At Home					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Labor					12b. KIND OF BUSINESS OR INDUSTRY Various														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland					13b. COUNTY Kent					13c. CITY OR TOWN Rock Hall					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					13e. STREET AND NUMBER									
14. FATHER'S NAME First Middle Last Jack William					15. MOTHER'S MAIDEN NAME First Middle Last Louella Tigghman																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? No or, (unknown) (If yes give war or dates of service)					16b. SOCIAL SECURITY NO. 220-28-0926					17. INFORMANT Address R.F.D. # Mrs. Walter Johnson Rock Hall, Md.																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident 428X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular insufficiency. DUE TO, OR AS A CONSEQUENCE OF non active T.B. of lungs															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min.														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 4221																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from 4-6-1967 , to 3-14-1968 , that (I) (we) lost saw the deceased alive on 3-14-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. at 8 pm.																													
22b. SIGNATURE Rudolf Eglitis					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. <input type="checkbox"/> STAFF <input type="checkbox"/> DIRECTOR PHYS.					22c. DATE SIGNED 3-15-68																			
22d. PHYSICIAN'S NAME (Type) Rudolf Eglitis M.D.					22e. ADDRESS Rock Hall, Maryland																								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE 3/18/68					23c. NAME OF CEMETERY OR CREMATORY Edesville Cemetery					23d. LOCATION (City or Town) (County) (State) Rock Hall Kent Md.														
24. FUNERAL DIRECTOR Small, Wally					ADDRESS Chestertown, Md.					25a. REC'D BY REGISTRAR DATE MAR 20 1968					25b. REGISTRAR'S SIGNATURE Charles Judge														



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PHS-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or Print)			First Middle Last Luther Gibson Blackiston			2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> Month Day Year 3-31-68 19		2b. HOUR 2:30 PM		
3. SEX Male	4. RACE White	5. DATE OF BIRTH 2/1/05	6. AGE (in years last birthday) 63 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month 3 Day 31 Year 19 68		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S. born		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Kent		Md.		
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kent & Queen Anne's		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired custodian		12b. KIND OF BUSINESS OR INDUSTRY Education (school)				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Queen Anne's		13c. CITY OR TOWN Crumpton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME First Middle Last Wm. Gibson Blackiston			15. MOTHER'S MAIDEN NAME First Middle Last Susan Crew							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 216-14-9085		17. INFORMANT Wm. Blackiston (Son) Crumpton, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4120 CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) HYPERTENSIVE CARDIOVASCULAR DIS. Unknown (c) ARTERIOSCLEROTIC HEART DISEASE "								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4200										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		O. S. Gulbrandsen, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 4-1-68		ADDRESS (Street, city, town, or county) CHESTERTOWN - KENT		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April, 2, 1968		23c. NAME OF CEMETERY OR CREMATORY Crumpton Cemetery.		23d. LOCATION (City or Town) (County) (State) Crumpton Q.A.Co; Md.				
24. FUNERAL DIRECTOR Edward Fellows & Son, Millington, Md. 21651				25a. REC'D BY REGISTRAR DATE APR 3 - 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge				

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CERTIFICATE OF DEATH

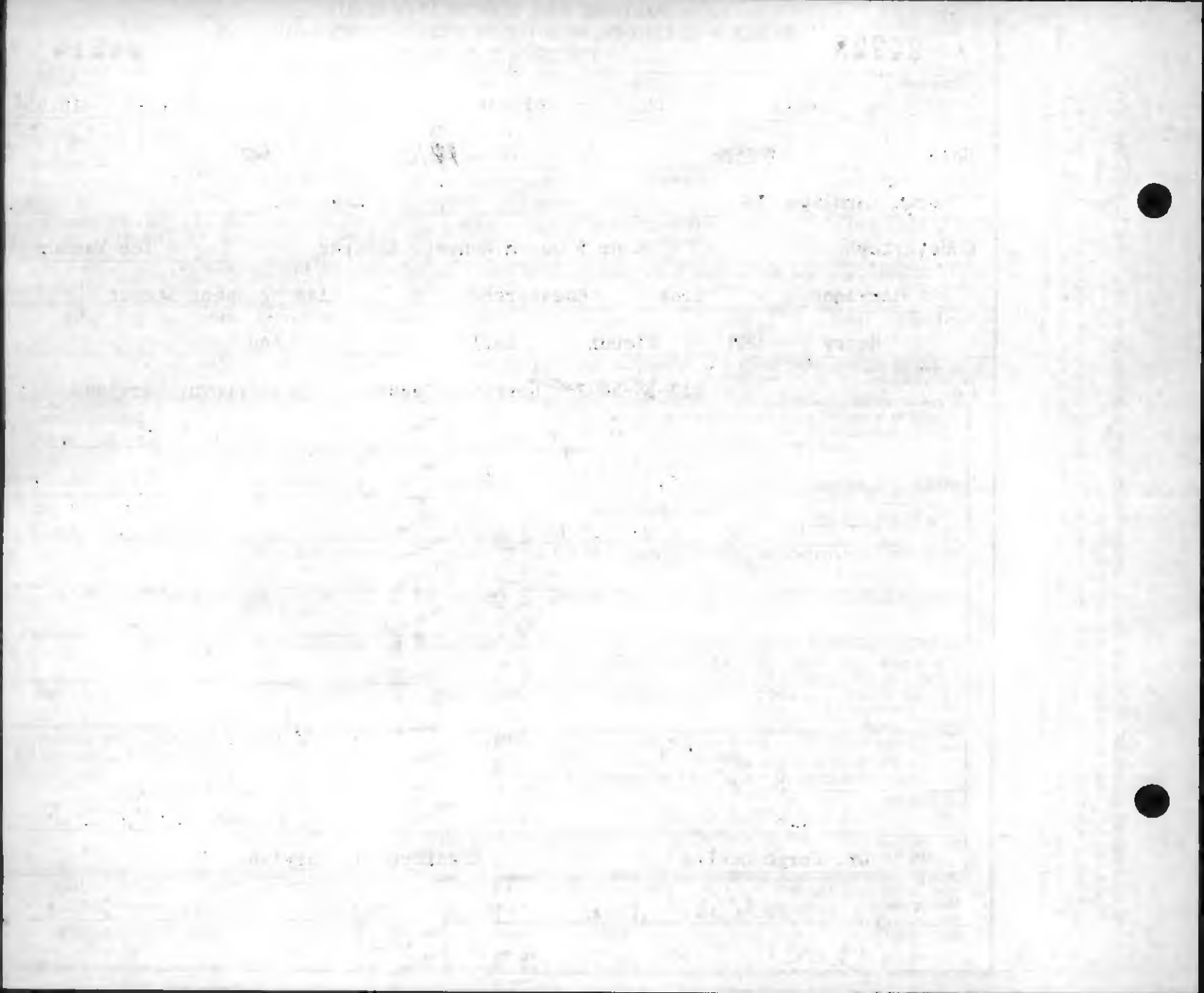
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1. DECEASED-NAME (Type or print) Thomas			First Thomas			Middle NMN			Last Blount			2a. DATE OF DEATH Month 3 Day 9 Year 1968			2b. HOUR 10:55											
3. SEX Male			4. RACE Negro			5. DATE OF BIRTH 8/15/1910			6. AGE (In years lost birthday) 57 YRS.			IF UNDER 1 YEAR MONTHS 0 DAYS 0			IF UNDER 24 HRS. HOURS 0 MIN. 0											
7a. BIRTHPLACE (State or foreign country) North Carolina			7b. CITIZEN OF WHAT COUNTRY? US			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Kent Co., Md.																	
10. CITY OR TOWN OF DEATH Chestertown			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kent & Queen Annes			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Laborer			12b. KIND OF BUSINESS OR INDUSTRY Ice Vender																	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Kent			13c. CITY OR TOWN Chestertown			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER 148 Prospect Street														
14. FATHER'S NAME First Henry Middle NMN Last Blount			15. MOTHER'S MAIDEN NAME First Sally Middle Ann Last Blount																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 213-18-5807			17. INFORMANT Address Hospital Records Chestertown, Maryland																				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) URSEMIA 591X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Kidney FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) Hydro-nephrosis															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 MONTHS FEW MONTHS SEVERAL YEARS											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 601X																										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State																				
22a. I certify that (I) (this hospital) attended the deceased from Jan. 23 , 19 68 , to March 9 , 19 68 , that (I) (we) last saw the deceased alive on March 9 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																										
22b. SIGNATURE Jorge Oteiza															DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/>			MED. DIRECTOR <input type="checkbox"/>			STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 3-11-68		
22d. PHYSICIAN'S NAME (Type) Dr. Jorge Oteiza															22e. ADDRESS Chestertown, Maryland											
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 3/13/68			23c. NAME OF CEMETERY OR CREMATORY JAMES CEM.			23d. LOCATION (City or Town) (County) (State) Chestertown Md.																	
24. FUNERAL DIRECTOR James W. ...															25a. REC'D BY REGISTRAR DATE MAR 14 1968			25b. REGISTRAR'S SIGNATURE James W. ...								



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Mary Elizabeth Clark		2a. DATE OF DEATH Month 3 Day 15 Year 1968		2b. HOUR 2:15 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 11/19/85	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kent & Queen Anne's Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Kent		13c. CITY OR TOWN Still Pond	
14. FATHER'S NAME First Middle Last Charles E Toulson		15. MOTHER'S MAIDEN NAME First Middle Last Susie Emma Wilmer		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, no, or unknown) No	
16b. SOCIAL SECURITY NO. 214-46-2650		17. INFORMANT Hospital Records		Address Chestertown, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal failure (uremia) + 4120 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 443X (b) Hypertension CVA - DUE TO, OR AS A CONSEQUENCE OF (c) Nephrosclerosis -					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3 months unknown unknown
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Severe secondary anemia - due to renal failure					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from March 7, 1968 , to March 15, 1968 , that (I) (we) last saw the deceased alive on March 15, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Dr. Robert W. Farr		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3/15/68	
22d. PHYSICIAN'S NAME (Type) Dr. Robert W. Farr		22e. ADDRESS Chestertown, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 3-18-68		23c. NAME OF CEMETERY OR CREMATORY STILL POND CEMTY	
23d. LOCATION (City or Town) STILL POND		(County) KENT		(State) MD	
24. FUNERAL DIRECTOR VICTOR N. KENNEDY		ADDRESS STILL POND, MD		25a. REC'D BY REGISTRAR MAR 18 1968	
				25b. REGISTRAR'S SIGNATURE Charles Jones	

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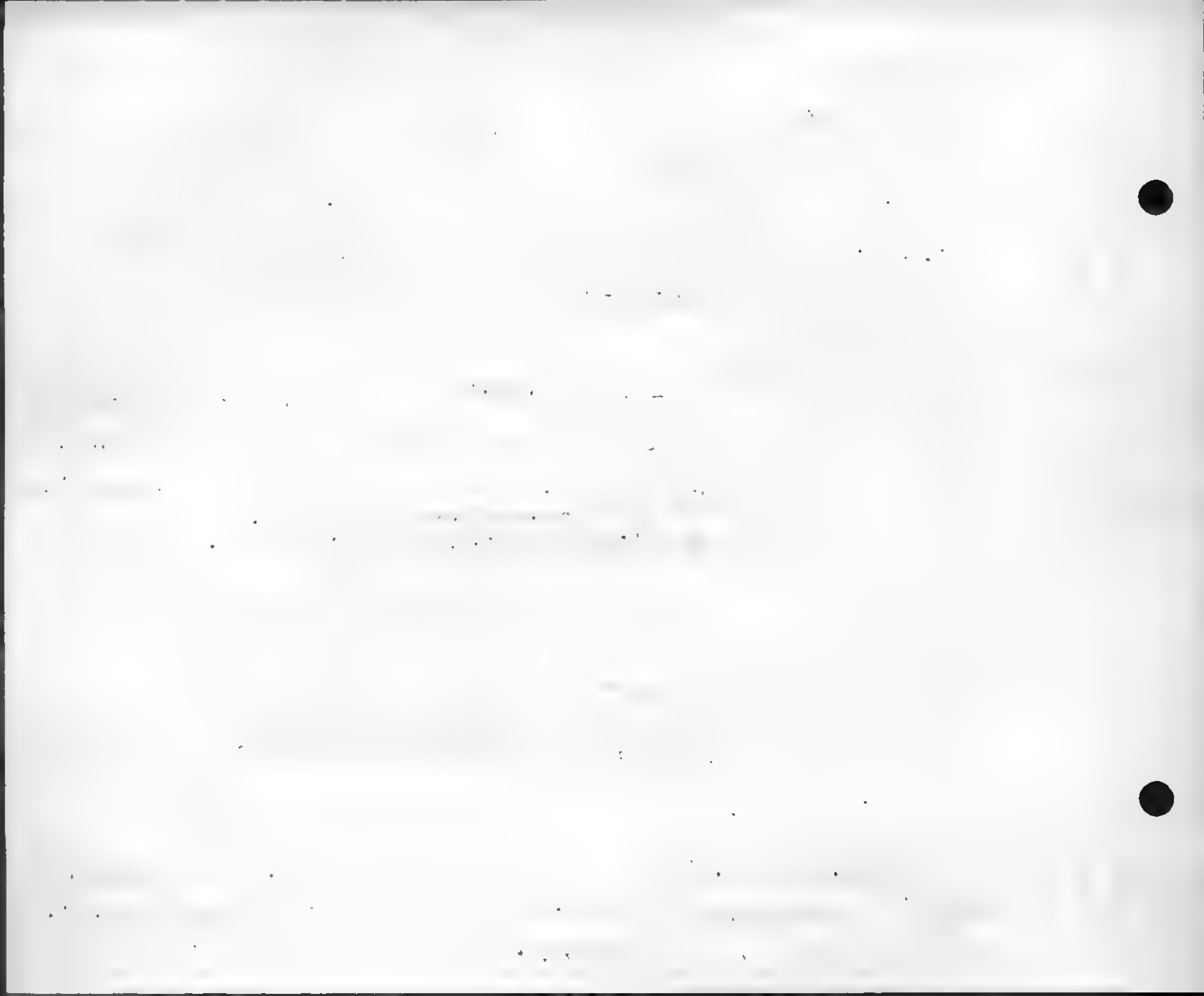
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) First Middle Last Elsie Elizabeth Duckery			2a. DATE OF DEATH Month 3 Day 17 Year 68		2b. HOUR a 9:40 M
3 SEX Female	4. RACE Negro	5. DATE OF BIRTH 6/23/17		6. AGE (In years lost birthday) 50 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Delaware	7b. CITIZEN OF WHAT COUNTRY? America	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Kent County Md		
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kent & Queen Anne's		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife	12b. KIND OF BUSINESS OR INDUSTRY None
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. CITY Millington	13c. CITY OR TOWN Millington	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER None
14. FATHER'S NAME First Middle Last Chester N.M.N. Wilson			15. MOTHER'S MAIDEN NAME First Middle Last Maggie N.M.N. Cammille		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO 213-22-6963		17. INFORMANT Wilbert Clarence Duckery Address Millington, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial Hemorrhage 4120 DUE TO, OR AS A CONSEQUENCE OF (b) Aneurysm, intracranial branch of DUE TO, OR AS A CONSEQUENCE OF internal carotid artery. (c) Hypertensive cardiovascular disease. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days 2 years "					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4431					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 3/13/68 , 19 68 , to 3/17 , 19 68 , that (I) (we) last saw the deceased alive on 3/17/68 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Dr. Robert W. Farr				22c. DATE SIGNED 3-17-68	
22d. PHYSICIAN'S NAME (Type) Dr. Robert W. Farr				22e. ADDRESS 305 Washington Ave. Chestertown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE March, 21, 1968		23c. NAME OF CEMETERY OR CREMATORY Chesterville Cemetery	
23d. LOCATION (City or Town) (County) (State) Millington, rural, Kent, Md.					
24. FUNERAL DIRECTOR Edward Fellows & Son,				25a. RECD BY REGISTRAR DATE MAR 21 1968	
ADDRESS Millington, Md. 21651				25b. REGISTRAR'S SIGNATURE James J. Young	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove category papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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VR A15 (11)
30M REV 1-68

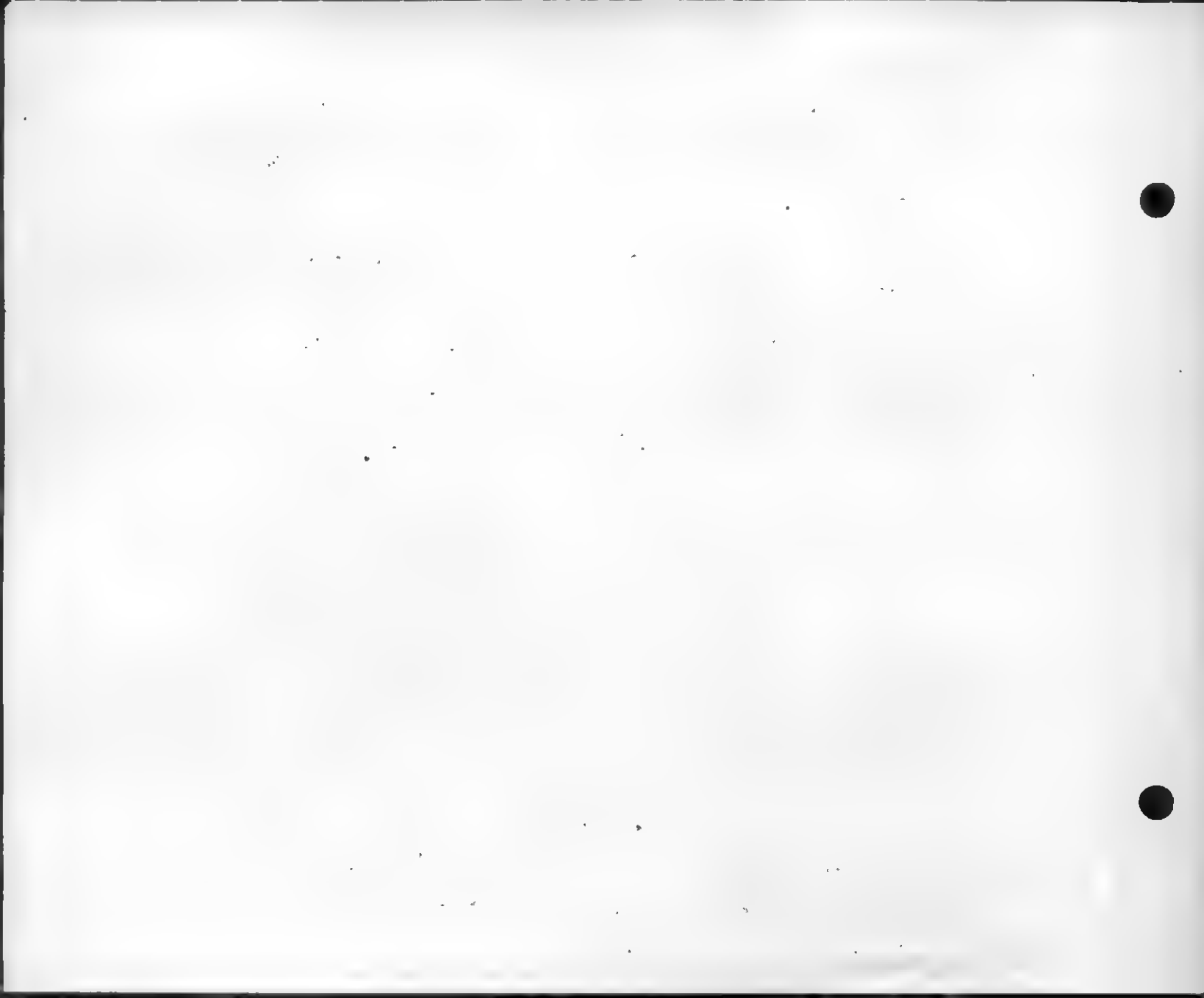
1

34232

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First Middle Last Harry Goodman			2a. DATE OF DEATH Month Day Year Mar. 12, 1968			2b. HOUR 8 P.M.							
3 SEX male		4. RACE white		5. DATE OF BIRTH 9/12/1881		6. AGE (in years) last birthday 86 85 YRS		7. UNDER 1 YEAR MONTHS DAYS 85		8. UNDER 24 HRS HOURS MIN 85			
7a. BIRTHPLACE (State or foreign country) Kent Co. Md.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Kent			Md	
10. CITY OR TOWN OF DEATH Lynch			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) At home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Ret. Waterman			12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.			13b. COUNTY Kent			13c. CITY OR TOWN Lynch			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER	
14. FATHER'S NAME First Middle Last James Goodman						15. MOTHER'S MAIDEN NAME First Middle Last Margaret Hadaway							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no (If yes give war or dates of service)			16b. SOCIAL SECURITY NO 220 32 9446			17. INFORMANT Mrs. Hilda Bedwell - Lynch, Md.			Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Impairment of advancing years 194 X DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 7-4 X													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 1-2 , 1968, to 3-12 , 1968, that (I) (we) last saw the deceased alive on 3-11 , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE A. C. Dick												22c. DATE SIGNED 3/12/68	
22d. PHYSICIAN'S NAME (Type) A. C. Dick												22e. ADDRESS Chestertown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 3/15/68			23c. NAME OF CEMETERY OR CREMATORY Chester Cemetery			23d. LOCATION (City or Town) (County) (State) Chestertown, Md.				
24. FUNERAL DIRECTOR J. Willis Wells						ADDRESS Chestertown, Md.			25a. REC'D BY REGISTRAR MAR 15 1968			25b. REGISTRAR'S SIGNATURE Charles Jones	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

MIDDLE
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First Middle Last Mabel Ellsworth Gosnell			2a. DATE OF DEATH Month Day Year 3 12 1968		2b. HOUR 12:30 AM
3 SEX Female	4 RACE White	5. DATE OF BIRTH 10/16/02		6. AGE (In years last birthday) 65 YRS.	IF UNDER 24 HRS MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) New York	7b. CITIZEN OF WHAT COUNTRY? US	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Kent Co. Md	
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kent & Queen Anne's Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Kent	13c. CITY OR TOWN Millington	13d. INSIDE CITY LIM TSP YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Rt. #1
14. FATHER'S NAME First Middle Last Lloyd B. Clyde Alyn Gosnell			15. MOTHER'S MAIDEN NAME First Middle Last Mabel Ellsworth Dibble		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? No Yes, no, or unknown (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 155-03-5723		17. INFORMANT Address Hospital Records Chestertown, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEVERE PULMONARY FIBROSIS DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMONIA TERMINAL DUE TO, OR AS A CONSEQUENCE OF (c) CHRONIC PASSIVE CONGESTION-LUNG Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last: 4802					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) ① INFLUENZA - INITIALLY ② DUODENAL ULCER					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 2-17 , 19 68 , to 3-12 , 19 68 , that (I) (we) last saw the deceased alive on 3-12 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Harry Paul Ross				22c. DATE SIGNED 3-12-68	
22d. PHYSICIAN'S NAME (Type or print) Dr. Harry Paul Ross				22e. ADDRESS Chestertown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/15/68		23c. NAME OF CEMETERY OR CREMATORY Mt. Hope Meth. Cem.	
23d. LOCATION (City or Town) (County) (State) Media Pa. Delaware Co.					
24. FUNERAL DIRECTOR J. Willis Wells				25a. REC'D BY REGISTRAR DATE MAR 15 1968	
ADDRESS Chestertown, Md.				25b. REGISTRAR'S SIGNATURE [Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VA FORM 104
304a REV. 1/68

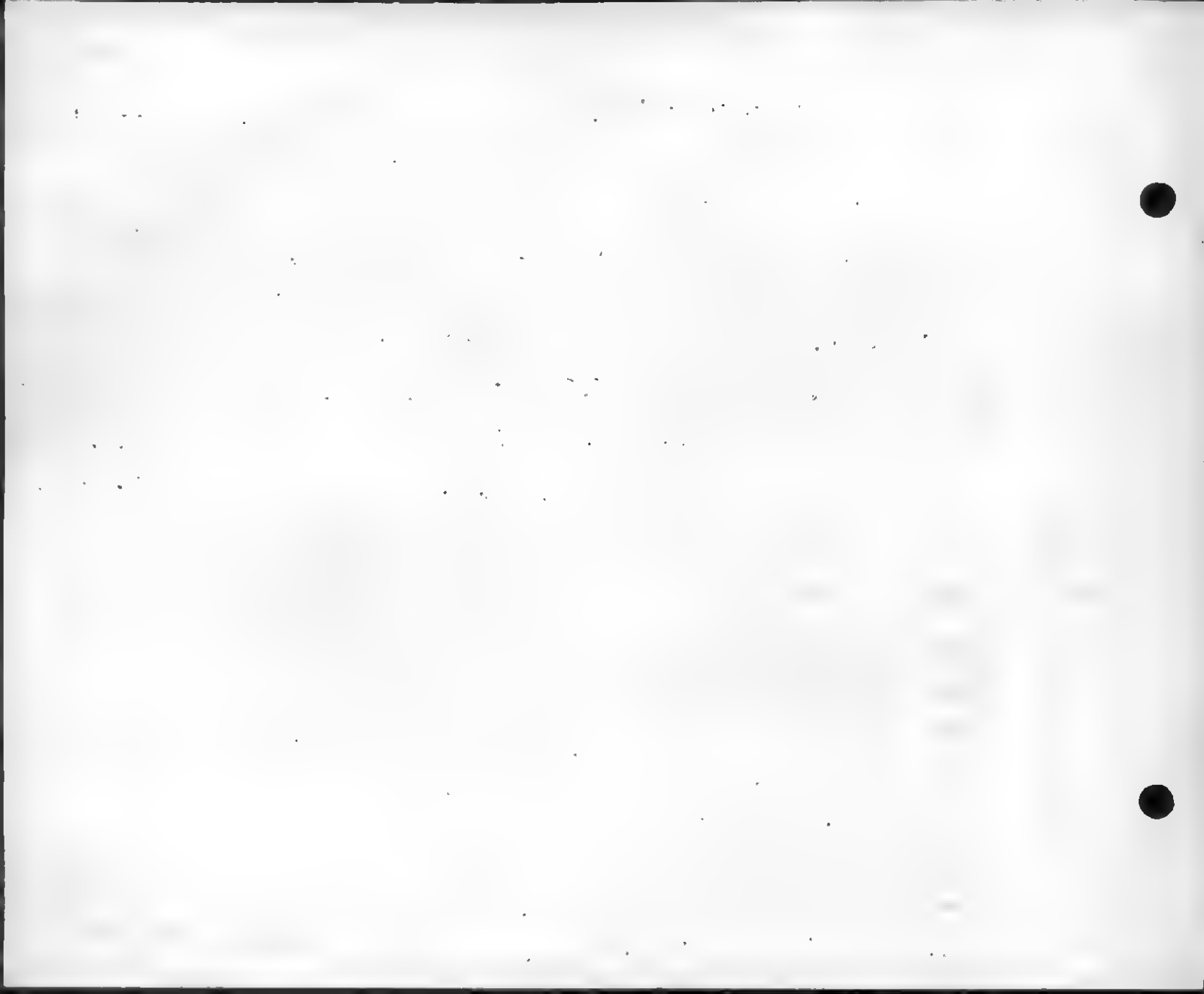
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04219

1. DECEASED-NAME (Type or print) Morgan Brown Hadaway			2a. DATE OF DEATH Month March Day 3 Year 1968			2b. HOUR 11 PM	
3 SEX male		4 RACE white		5. DATE OF BIRTH 9/20/1910		6. AGE (In years lost birthday) 57 YRS	
7a. BIRTHPLACE (State or foreign country) Kent Co. Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Kent Md	
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cross St.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Gas Company Retired		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Md.		13b. COUNTY Kent		13c. CITY OR TOWN Chestertown		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
13e. STREET AND NUMBER Cross St.		14. FATHER'S NAME First Middle Lost Tilden C. Hadaway		15. MOTHER'S MAIDEN NAME First Middle Lost Marian Peterson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service) WW II		16b. SOCIAL SECURITY NO. 216 01 6367		17. INFORMANT Helen E. Williams		Address Chestertown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary Fibrosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden 10 yrs							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 525 X							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from March, 1959 to March, 1968 , that (I) (we) last saw the deceased alive on 3/3/1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Thomas J. Solon				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3/4/68	
22d. PHYSICIAN'S NAME (Type) Thomas J. Solon				22e. ADDRESS Chestertown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/6/68		23c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		23d. LOCATION (City or Town) (County) (State) Chestertown, Md.	
24. FUNERAL DIRECTOR Wells				ADDRESS Chestertown, Md.		25a. REC'D BY REGISTRAR DATE MAR 7 1968	
				25b. REGISTRAR'S SIGNATURE [Signature]			

MEDICAL CERTIFICATION

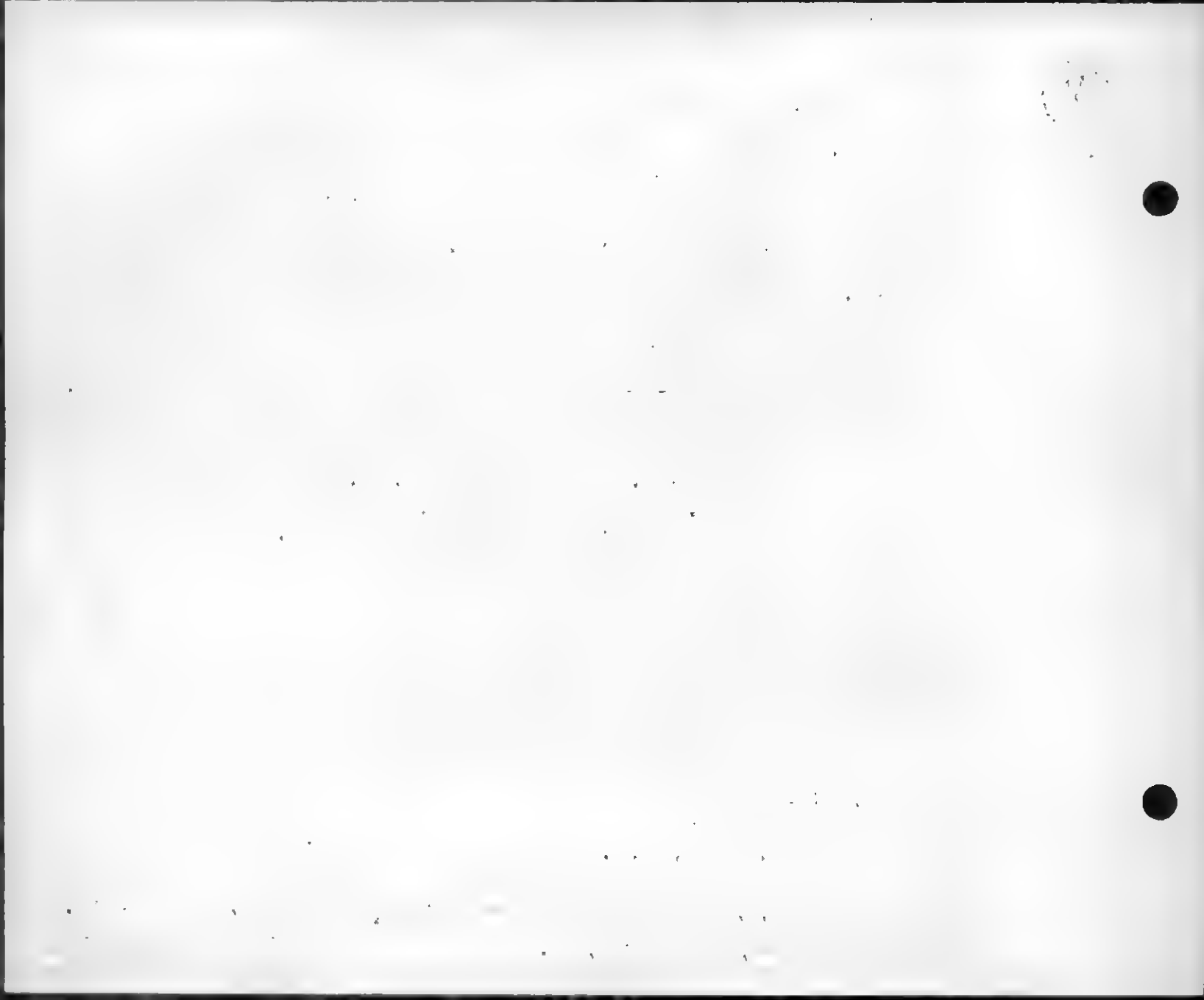


FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			2b HOUR		
Mary Elizabeth Hicks						Month Day Year			3 29 68 9 P M		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD			2d HOUR
Female	Col.	2/4/84	84 YRS					Month Day Year			9 P M
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			Md		
Maryland		USA				Kent					
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Chestertown			Kent & Queen Anne Hosp.			Housework			Domestic		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER			
Md.			Kent		Millington						
14 FATHER'S NAME First Middle Last				15 MOTHER'S MAIDEN NAME First Middle Last							
Samuel Dudley				Sarah Wilmer							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b SOCIAL SECURITY NO		17 INFORMANT			ADDRESS		
no				218-20-7555		Georgianna Demby			Millington, Md.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease several										months	
DUE TO, OR AS A CONSEQUENCE OF (b) Lived alone. Taken sick 3/26/68. Seen daily by step-daughter. Was getting worse. Brought to Kent and Queen Anne Hospital where she was dead on arrival.											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
			19								
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State						
22a I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b DATE SIGNED			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				3/30/68			
Robert W. Farr, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county)			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)				
Burial		April, 3, 1968		John Wesley Cemetery			Millington, Kent Md.				
24 FUNERAL DIRECTOR ADDRESS						25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
Edward Fellows & Son, Millington, Md. 21651						APR 2 - 1968		Charles Judge			



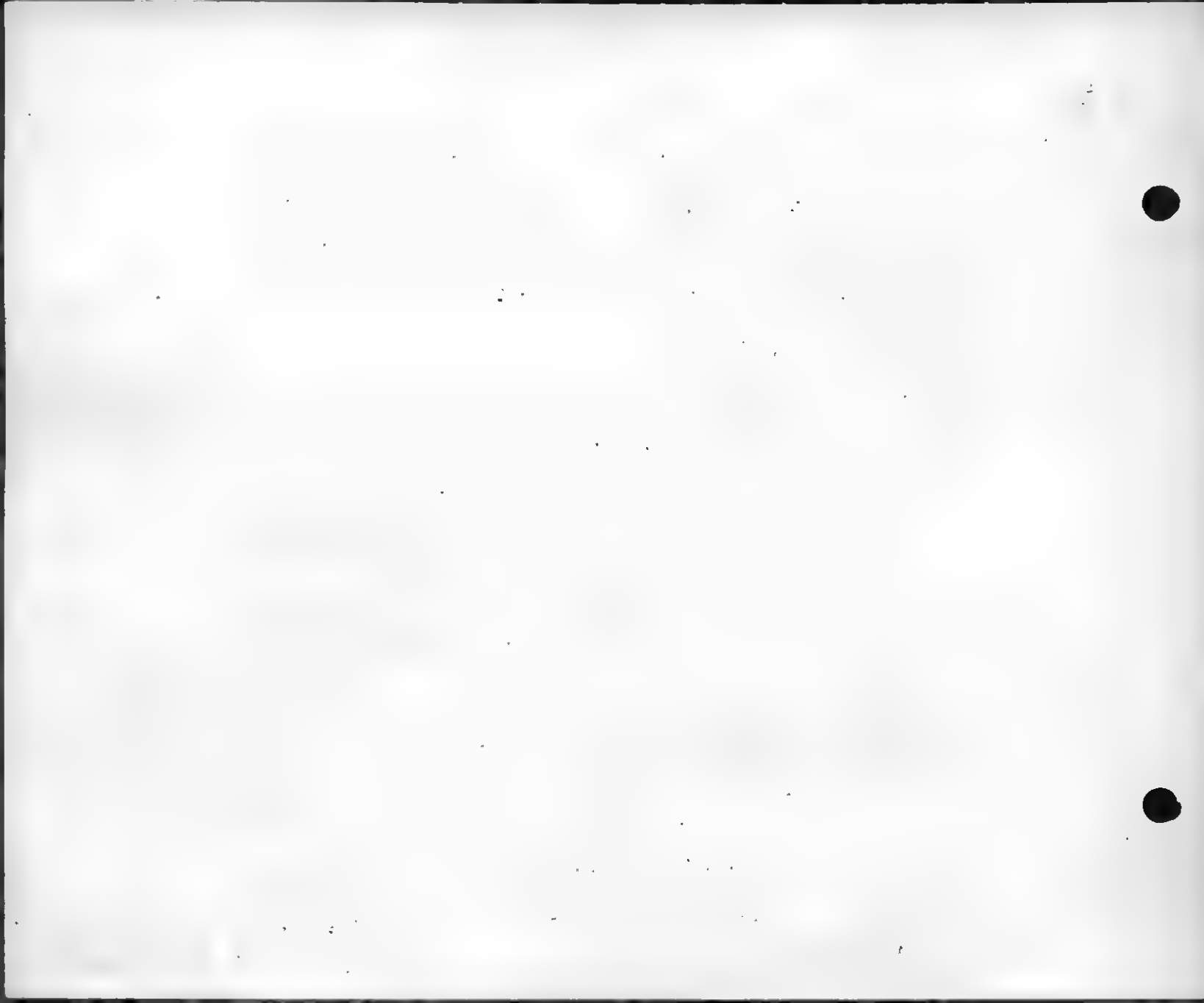
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (1)
30M REV. 7-68

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print) Elizabeth Ellis Hines			First Middle Last			2a. DATE OF DEATH Month Day Year March 29 1968		2b. HOUR 7:30am		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH Sept. 8, 1908		6. AGE (In years last birthday) 59 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Kent Md.				
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Quaker Neck Road		12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institut on. Residence before admission) STATE Maryland			13b. COUNTY Kent		13c. CITY OR TOWN Chestertown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Quaker Neck Road	
14. FATHER'S NAME First Middle Last Rudolph F. Tull				15. MOTHER'S MAIDEN NAME First Middle Last Elizabeth Coale						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO 215-44-5889		17. INFORMANT Address W. Dorsey Hines Chestertown Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarct 710.0 DUE TO, OR AS A CONSEQUENCE OF Essential hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 minutes 2 years		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from Jan. 3-29, 1968, that (I) (we) last saw the deceased alive on 3-21, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE A.C. Dick, M.D.						22c. DATE SIGNED # @ (3-29-68				
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS A.C. Dick, M.D. Chestertown, Maryland.								
23a. BURIAL, CREMATION, REMOVING BODY		23b. DATE 3-31-68		23c. NAME OF CEMETERY OR CREMATORY St. Paul's		23d. LOCATION (City or Town) (County) (State) Chestertown (Fairlee) Kent, Md.				
24. FUNERAL DIRECTOR Marvin V. Williams, Chestertown, Md.				25a. REC'D BY REGISTRAR DATE APR 2 - 1968		25b. REGISTRAR'S SIGNATURE Charles Judge				

MEDICAL CERTIFICATE ON



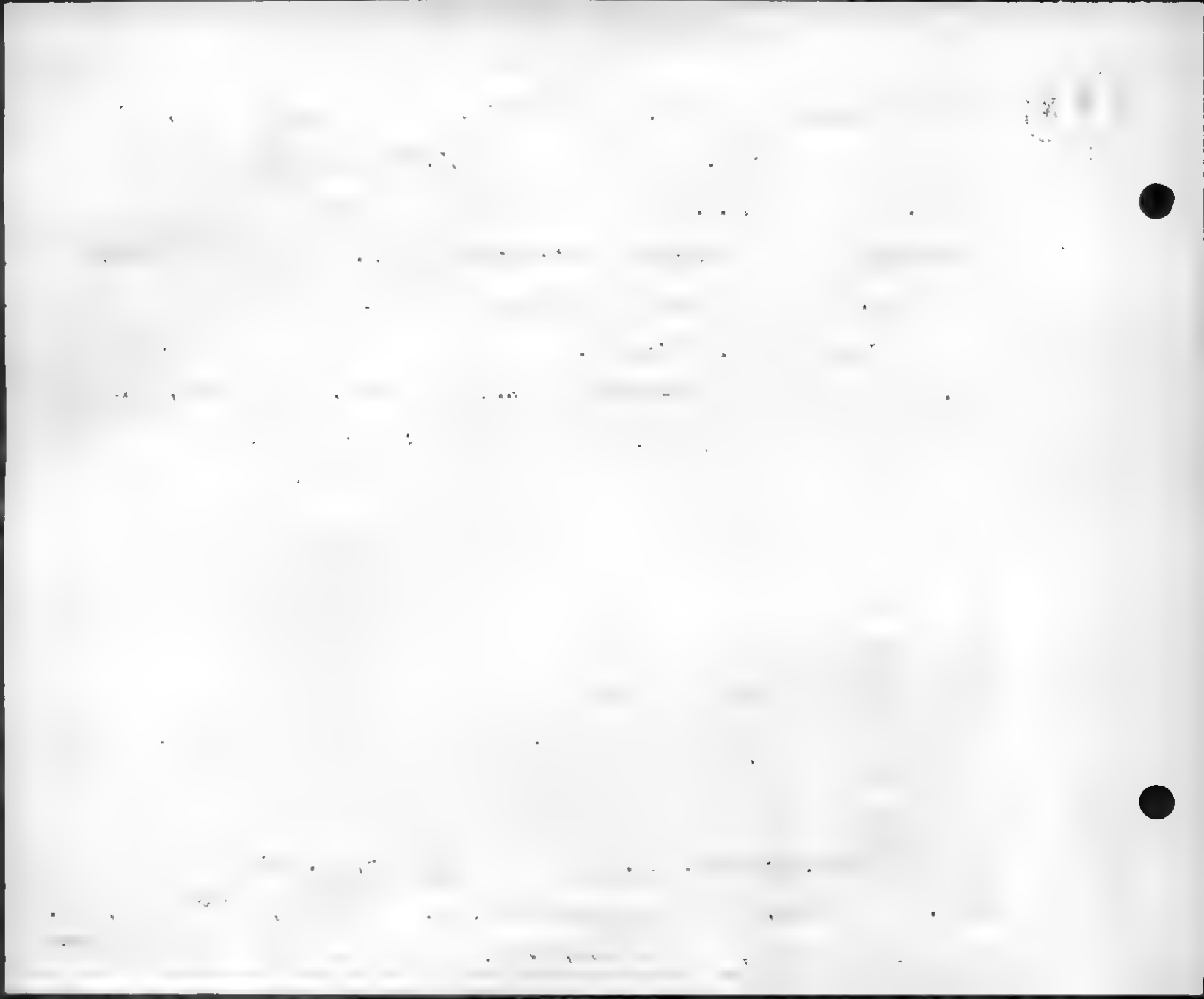
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 1515
30M REV. 1-76

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) GEORGE		First Middle Last F. MOFFETT.		2a. DATE OF DEATH Month March Day 30 Year 1968		2b. HOUR M	
3 SEX Male		4. RACE White.		5. DATE OF BIRTH July, 7, 1917		6. AGE (In years last birthday) 50 YRS.	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Kent Md	
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kent & Queen Ann's Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Club.		12b. KIND OF BUSINESS OR INDUSTRY Tavern	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Kent		13c. CITY OR TOWN Millington		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First Middle Last George R. Moffett.		15. MOTHER'S MAIDEN NAME First Middle Last Mary McDowell					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (yes, no, or unknown) No.		16b. SOCIAL SECURITY NO 148-05-0509		17. INFORMANT Address Mrs. Mary Moffett, Millington, Md. 21651			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of stomach with metastases in the brain and lungs. DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH One year.
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 101X							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from March 18, 1968 , to March 30, 1968 , that (I) (we) last saw the deceased alive on March 29, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Geza Koralewski MD				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 3.30.68	
22d. PHYSICIAN'S NAME (Type) Geza Koralewski, M.D.				22e. ADDRESS Millington, Md. 21651			
23a. BURIAL, CREMATION, or other disposition (Specify) Burial		23b. DATE April, 1, 1968		23c. NAME OF CEMETERY OR CREMATORY Old Bohemia Cemetery.		23d. LOCATION (City or Town) (County) (State) Warwick, Cecil, Md.	
24. FUNERAL DIRECTOR ADDRESS Edward Fellows & Son, Millington, Md. 21651				25a. REC'D BY REGISTRAR DATE APR 2 - 1968		25b. REGISTRAR'S SIGNATURE John R. Judge	

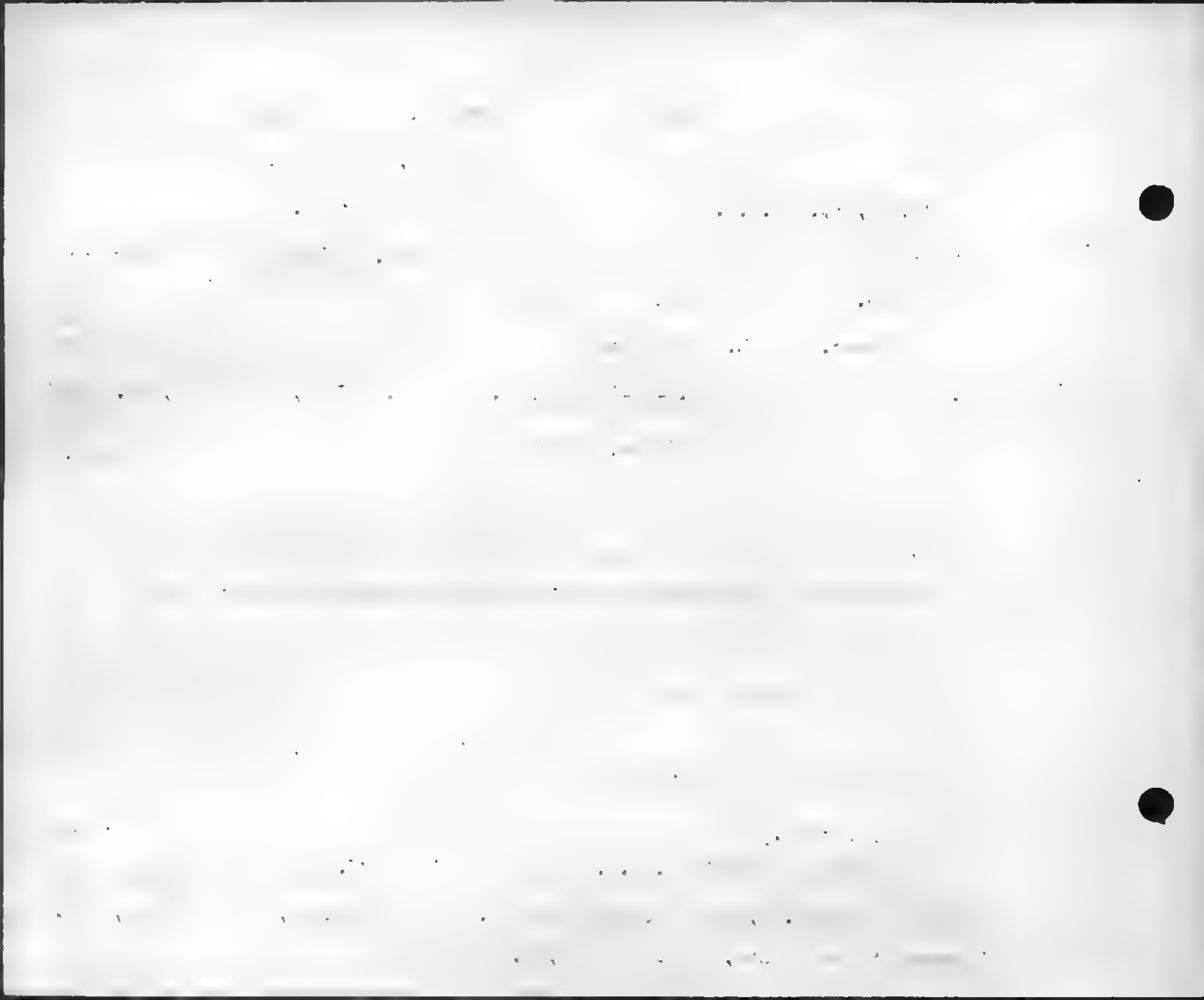


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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

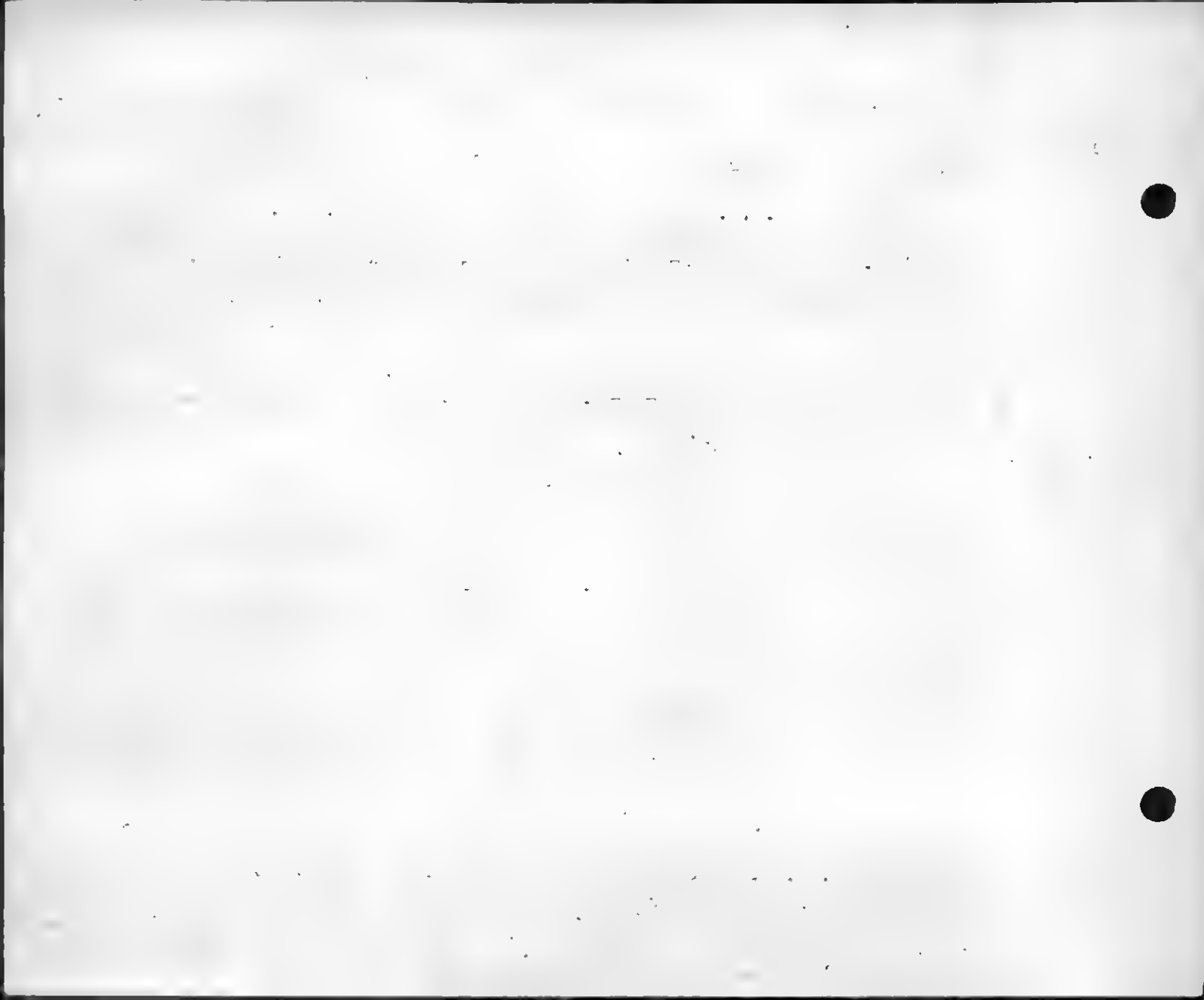
1 DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR	
JOHN RAYMOND MULFORD, Sr.					March 11, 1968		4 A M	
3. SEX	4 RACE	5. DATE OF BIRTH			6 AGE (In years last birthday)	7 UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN
Male	White	September, 27, 1899			68			
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Galena, Md.	U.S.A.			Kent.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Galena				Ret. Mechanic		Boat Co;		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER				
Md.	Kent	Galena						
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle
James. W. Mulford					Annie Thornley			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
No.		216-09-5211A		Mrs. Hilda B. Mulford,		Galena, Md. 21635		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Periarteritis nodosum</u> 4700 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>456</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Multip: e CVA Gangrene of rt foot, impending gangrene lt foot</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb 15</u> , 19 <u>68</u> , to <u>10 Mar 68</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>10 Mar 68</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Wallace Obenshain</u>						22c. DATE SIGNED <u>11 Mar ch 68</u>		
22d. PHYSICIAN'S NAME (Type) <u>Wallace Obenshain, M.D.</u>						22e. ADDRESS <u>Cecilton, Md. 21913</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	(State)
Burial		Mar. 13, 1968	Galena Cemetery.		Galena,		Kent,	Md.
24. FUNERAL DIRECTOR <u>Edward Fellows & Son,</u>			ADDRESS <u>Millington, Md. 21651</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 14 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>	



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MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201															
Item#4 Film#G399 4/4/68 km															
CERTIFICATE OF DEATH															
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR						
John Wesley Pearce						3 Month 24 Day 1968			3:20 A. M.						
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.				
Male		American White		3-17-1876			92 YRS.		MONTHS 4		DAYS 4				
7a. BIRTHPLACE (State or foreign country)			7b. CITIZENSHIP OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH						
Maryland			U.S.A.						Kent Co.			Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY						
Chestertown			Kent-Queen Anne's Hosp.			Farmer-Waterman-Ret.									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INS DE CITY LIMITS?			13e. STREET AND NUMBER			
Maryland			Kent			Rock Hall			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Route # 2			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME												
First Middle Last			First Middle Last												
Wesley ? Pearce ?			Julia ? Goodman												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address						
No			213-24-0449			Daughter			Rock Hall, Maryland						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cervix</u>												18 months?			
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Ca of lip</u>												2 years?			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
<u>Complications of advancing years.</u>															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
			HOUR A.M. Month Day Year P.M. 19												
21d. INJURY OCCURRED <input type="checkbox"/> While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)			21f. LOCATION			Street or R.F.D. No.			City or Town			
22a. I certify that (I) (this hospital) attended the deceased from 3-21, 1968, to 3-24, 1968, that (I) (we) last saw the deceased alive on 3-23-68, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE												22c. DATE SIGNED			
<u>Attila M.O.</u> DEGREE												3-24-68			
22d. PHYSICIAN'S NAME (Type)												22e. ADDRESS			
Dr. A. C. Dick												Morgnac Road Chestertown, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town)			(County) (State)			
Burial			3/26/68			Wesley Chapel Am			Rock Hall			Kent Md			
24. FUNERAL DIRECTOR												25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
<u>Marvin V. Williams</u> ADDRESS <u>Chestertown</u>												DATE <u>APR 28 1968</u>		<u>Charles Judge</u>	



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

225

1. DECEASED-NAME (Type or print) Ralph Glanding Plummer, Sr.			2a. DATE OF DEATH Month 3 Day 12 Year 1968		2b. HOUR 3:15AM
3 SEX Male	4 RACE White	5. DATE OF BIRTH 7/17/86		6. AGE (In years last birthday) 81 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? US	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Kent Co. Md.		
10. CITY OR TOWN OF DEATH Chestertown	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kent & Queen Anne's Hosp.		12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired.) Finance Business		12b. KIND OF BUSINESS OR INDUSTRY
13a. US.A. RESIDENCE (Where deceased lived, if institution; Residence before admision) STATE Maryland	13b. COUNTY Queen Anne's	13c. CITY OR TOWN Church Hill	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER None	
14. FATHER'S NAME First Middle Last Thomas Henry ? Plummer		15. MOTHER'S MAIDEN NAME First Middle Last Margaret Glanding			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 216-09-8180		17. INFORMANT Address Hospital Records Chestertown, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASCUD DUE TO, OR AS A CONSEQUENCE OF (b) Chronic passive cong of lungs DUE TO, OR AS A CONSEQUENCE OF (c) UREMIA due to chronic RENAL FAILURE PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21f. LOCATION Street or R.F.D. No City or Town County State	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING ETC.		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from March 7, 1968 , to March 12, 1968 , that (I) (we) last saw the deceased alive on March 12, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Harry P. Ross, MD		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3-12-68	
22d. PHYSICIAN'S NAME (Type) Dr. H. P. Ross		22e. ADDRESS Chestertown, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE MARCH 14	23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET		23d. LOCATION (City or Town) (County) (State) BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR Edgar D. Lane - CHURCH HILL MD.		ADDRESS CHURCH HILL MD.		25a. REC'D BY REGISTRAR MAR 19 1968	25b. REGISTRAR'S SIGNATURE Charles Judge



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VR A15 (4)
30M REV. 1/68

MDARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

04241		04226	
1. DECEASED-NAME (Type or print) First Middle Last Luther Toulson Ward			
2a. DATE OF DEATH Month Day Year 3 16 1968		2b. HOUR 6:00P ^M	
3. SEX Male	4. RACE Negro	5. DATE OF BIRTH 8/20/1898	6. AGE (In years last birthday) YRS. MONTHS DAYS 69
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? US	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Kent Co. Md.
10. CITY OR TOWN OF DEATH Chestertown	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kent & Queen Anna's Hosp.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Ret. - Farmer	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Kent	13c. CITY OR TOWN Rock Hall	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME First Middle Last Louis NMN Ward	15. MOTHER'S MAIDEN NAME First Middle Last Lucy NMN Barryman	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) No	
16b. SOCIAL SECURITY NO. YES		17. INFORMANT Address Hospital Records Chestertown, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute hypertrophy with urinary retention & uremia</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>chronic glomerulonephritis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerotic CVD</i> Approximate interval between onset and death: <i>Don't know at least 9 years Don't know</i>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>4221</i>			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>March 15</u> , 19 <u>68</u> , to <u>March 16</u> , 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>March 16</u> , 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>Robert W. Farr</i>	DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 3/19/68	
22d. PHYSICIAN'S NAME (Type) Dr. Robert W. Farr		22e. ADDRESS Chestertown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>	23b. DATE 3/21/1968	23c. NAME OF CEMETERY OR CREMATORY AARON CEMETERY	23d. LOCATION (City or Town) (County) (State) Rock Hall, Kent, Md
24. FUNERAL DIRECTOR <i>Senetha Wells</i>	ADDRESS Chestertown, Md	25a. REC'D BY REGISTRAR DATE MAR 21 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																																			
CERTIFICATE OF DEATH																																			
1. DECEASED-NAME (Type or print)						First Middle Last						2a. DATE OF DEATH						2b. HOUR																	
Marcie						Wilson						Month 5 Day 25 Year 68						2:00 AM																	
3. SEX				4. RACE				5. DATE OF BIRTH				6. AGE (In years last birthday)				IF UNDER 1 YEAR				IF UNDER 24 HRS.															
Female				Colored				11/17/1898				69 YRS.				MONTHS				DAYS															
7a. BIRTHPLACE (State or foreign country)				7b. CITIZEN OF WHAT COUNTRY?				8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH																							
Maryland				U.S.A.								Kent County				Md.																			
10. CITY OR TOWN OF DEATH						11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)						12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)						12b. KIND OF BUSINESS OR INDUSTRY																	
R.F.D. #2 Chestertown						At Home						Labor						Various																	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE						13b. COUNTY						13c. CITY OR TOWN						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						13e. STREET AND NUMBER											
Maryland						Kent						Chestertown						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						R.F.D. #2											
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME																													
First Middle Last						First Middle Last																													
John H. Smith						Ella Broadway																													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16b. SOCIAL SECURITY NO.						17. INFORMANT						Address																	
No						218-20-6281						Mr. Linwood Wilson						R.F.D. #2 Chestertown, Md.																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																	
PART I. DEATH WAS CAUSED BY:																																			
IMMEDIATE CAUSE (a) Cardiovascular disease, per dissection of aneurysm of abdominal aorta																																			
4129 DUE TO, OR AS A CONSEQUENCE OF																																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																																			
(b) Atherosclerosis																																			
DUE TO, OR AS A CONSEQUENCE OF																																			
(c)																																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																			
4221 Chronic colitis at times with bleedings																																			
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)						21b. TIME OF INJURY						21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																							
						HOUR A.M. Month Day Year																													
						P.M. 19																													
21d. INJURY OCCURRED						21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)						21f. LOCATION						Street or R.F.D. No. City or Town County State																	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>																																			
22a. I certify that (I) (this hospital) attended the deceased from 2-8-64, 1964, to 3-24-1968, that (I) (we) last saw the deceased alive on 3-24-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																			
22b. SIGNATURE																		DEGREE						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED					
Rudolf E. Egitis																														3-26-68					
22d. PHYSICIAN'S NAME (Type)																		22e. ADDRESS																	
Rudolf E. Egitis M.D.																		Rock Hall, Maryland																	
23a. BURIAL, CREMATION, REMOVAL (Specify)						23b. DATE						23c. NAME OF CEMETERY OR CREMATORY						23d. LOCATION (City or Town) (County) (State)																	
Burial						3/30/68						Fairlee Cemetery						Chestertown Kent Md																	
24. FUNERAL DIRECTOR																		ADDRESS						25a. REC'D BY REGISTRAR						25b. REGISTRAR'S SIGNATURE					
Kenneth W. Wally																		Chestertown, Md.						DATE MAR 29 1968						Charles Judge					



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